NEW ENGLAND RETINA CONSULTANTS. P.C.

DAVID D. AGAHIGIAN, M.D. BRADLEY S. FOSTER, M.D. ANDREW LAM, MD

PT. NAME ______________________________ DOB ______________

You have been given information about your condition and the recommended surgical, medical or diagnostic procedures to be used. This consent form is designed to provide a written confirmation of such discussions by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

CONSENT TO: LASER TREATMENT

PDT LASER

CRYOPEXY

OTHER IN OFFICE MEDICAL PROCEDURE

Dr ____________________________has explained to me that the following conditions exist in my case:

____

I understand that the procedures proposed for evaluating and treating my condition is(are):

____**eye**

The available alternative is____

Just as there may be benefits to the procedure proposed, I also understand that this procedure, like all medical and surgical procedures, can have risks. These risks can include but are not limited to bleeding, blood clots, infections, adverse side effects of drugs, or allergic reactions to drugs, and even loss of bodily function or life.

I am aware that in the practice of medicine other unexpected risks or complications not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed which, in my physician's medical judgement, warrants that additional procedures be performed at the same time. I authorize that such procedures be performed I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment.

The potential benefits and risks of the proposed procedure(s), and the likely results of not having such treatments have been explained to me. I understand what has been discussed with me as well as the contents of this consent form. I have been given the opportunity to ask questions and have received satisfactory answers. I have had the opportunity to speak with a family member.

Having read this form and talked with my physician, my signature below acknowledges that: I voluntarily give my consent to the above described procedure(s) or treatrnent(s) to be performed by my physician and/or his/her delegated assistants and other trained facility personnel.

Patient____**Date:**____________________

Physician____